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REPORT ON WORKSHOP SESSION

CLINICAL EVALUATION, STAGING AND PROGNOSIS

Committee Members

Paul P. Carbone, M. D.
Ronald Castellino, M. D.
Paul Hoffer, M. D.
A. M. Jelliffe, M. D.
Henry S. Kaplan, M. D.
Saul A. Rosenberg, M. D.
Maurice Tubiana, Professor
John E. Ultmann, M. D.
Chairman

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REPORT ON WORKSHIP SESSION - J. E. ULTMANN, Chairman

CLINICAL EVALUATION, STAGING AND PROGNOSIS

The first part of the meeting was devoted to a discussion of new techniques in evaluating extent of disease and assessing the host's immunologic status.

Professor Tubiana inquired regarding present research in assessing immunologic responsiveness. He commented regarding the discrepancy between various reports depending on patient material studied and techniques employed. It was recommended that a careful definition of immunologic responsiveness of a control population be undertaken and that techniques thus developed be applied to untreated, carefully staged patients with HD.

Dr. Strum raised a question regarding use of lung-mediastinal tomography. Although ideally this technique might be employed routinely, its use of necessity must often be restricted. It is particularly important to perform when routine PA and lateral roentgenologic examination show abnormalities. With bilateral neck involvement, there is a great likelihood that the mediastinum is involved. Whole lung tomography may also be helpful in patients with clinical symptoms and elevated erythrocyte sedimentation ^{rate} when other tests are negative.

The usefulness of bone marrow biopsy was reviewed by Dr. Rosenberg, who summarized the data previously reported by him in Cancer Research (November 1971).

No new information regarding predictive parameters for liver involvement (other than splenic involvement at laparotomy) was developed.

Dr. Hoffer reviewed his experience with ^{99}Tc scans of bone marrow performed in conjunction with liver-spleen scans. The cost-time factor appears small. Correlation in individual cases with the ^{18}F scan was stressed. There are no studies reported correlating radiologic and isotope studies of bone and bone marrow with biopsy results and such an investigation should be encouraged.

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Dr. Castellino reviewed the Stanford experience with 33 patients who had splenic arteriography in an attempt to predict splenic involvement. This was found not to be a useful procedure.

It is estimated that over 2,000 laparotomies and splenectomies for staging Hodgkin's disease have been performed to date. Current reports stress the diagnostic value of this procedure. However, there is little information available regarding the immediate and long-term risks. It was proposed that a canvass of university, as well as community, hospitals be undertaken to compile the incidence of complications - operative, post-operative, and long-range. The risk-reward ratio, particularly in hospitals having little experience with this procedure, should be determined.

The second part of the meeting consisted of a discussion of the usefulness of staging patients in relapse. It was emphasized how important precise restaging is in determining treatment strategy. It is recommended that the current nomenclature developed for primary staging (Ann Arbor Classification) not be applied to patients in relapse.

For patients who have had only radiotherapy in the past and who are found to be in relapse, the following designations are suggested:

Local recurrence⁺ - This is a recurrence in area previously treated.*
(LR or TR) Tumor dose of RT previously given should be specified.

Regional recurrence⁺ - This is a recurrence outside the previously treated
(MR, Adj R) area*; however, it is confined to the same side of the diaphragm where disease was found initially.

Transdiaphragmatic recurrence⁺ - This signifies appearance of disease in
(TDR) lymph nodes (or spleen) but on the other side of the diaphragm than originally noted.

Extra-lymphatic recurrence⁺ - This is the appearance of disease in extra
(EL) nodal or extra splenic sites and may be designated as L+, H+, M+, D+, etc.

*At times, it is difficult to differentiate a local recurrence from a marginal recurrence.

+More than one type of recurrence may be present in a single patient. Each type should be coded.

For patients who have had chemotherapy or chemotherapy and radiotherapy, the relapse designations should be kept very simple:

Recurrence - This designates reappearance of disease in one or multiple sites as observed during prior staging.

Local problems - These should be designated specifically when they appear in a patient following administration of chemotherapy.

The panel stressed the importance of staging in relapse to determine accurately treatment strategy. Additional biopsies, including, occasionally laparotomy, are considered useful.